# Medicaid 101

Title XIX Advisory Committee Retreat
January 27, 2006

Doug Porter,
Assistant Secretary,
Health and Recovery Services Administration,
DSHS

# Today's presentation:

- **Part I:**
  Current coverage under Medicaid and other medical assistance programs
- **Part II:**
  Spending and caseload growth
- **Part III:**
  HRSA organization
- **Part III**
  Cost containment efforts
- **Part IV**
  Medicaid Reform proposals

# Part I:
# Current coverage

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# Medical assistance programs

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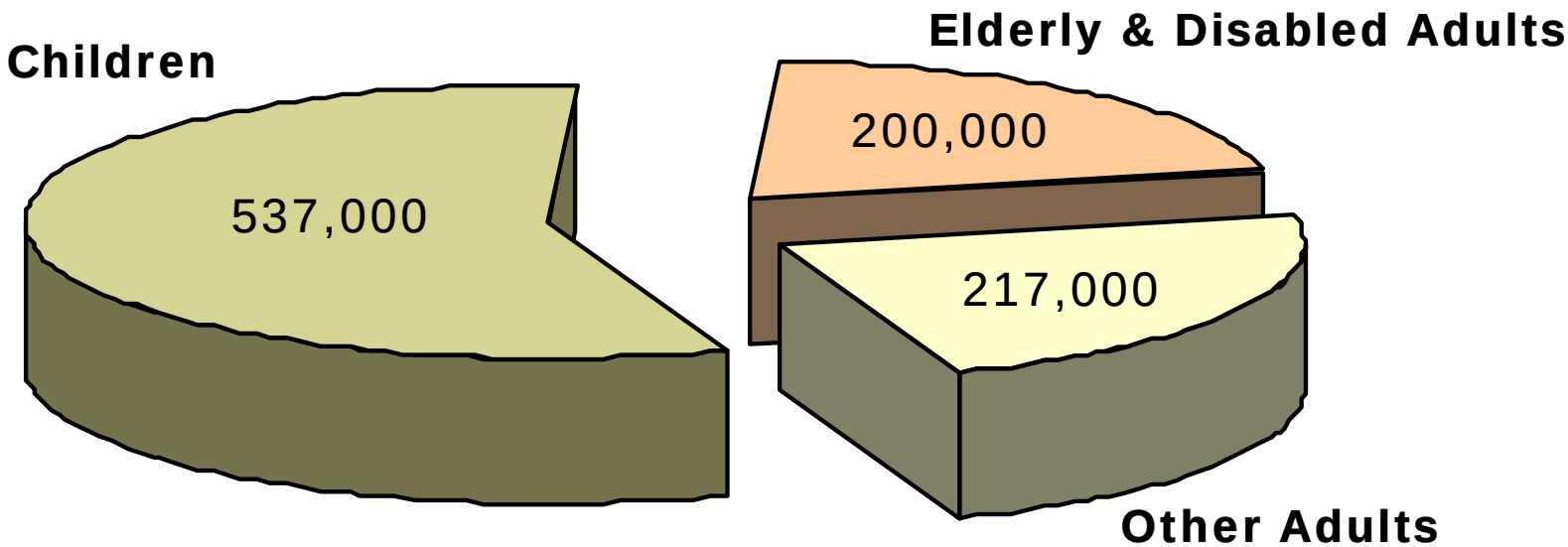
The state is paying for medical coverage for an average of almost 1 million low-income Washington residents each month this biennium.

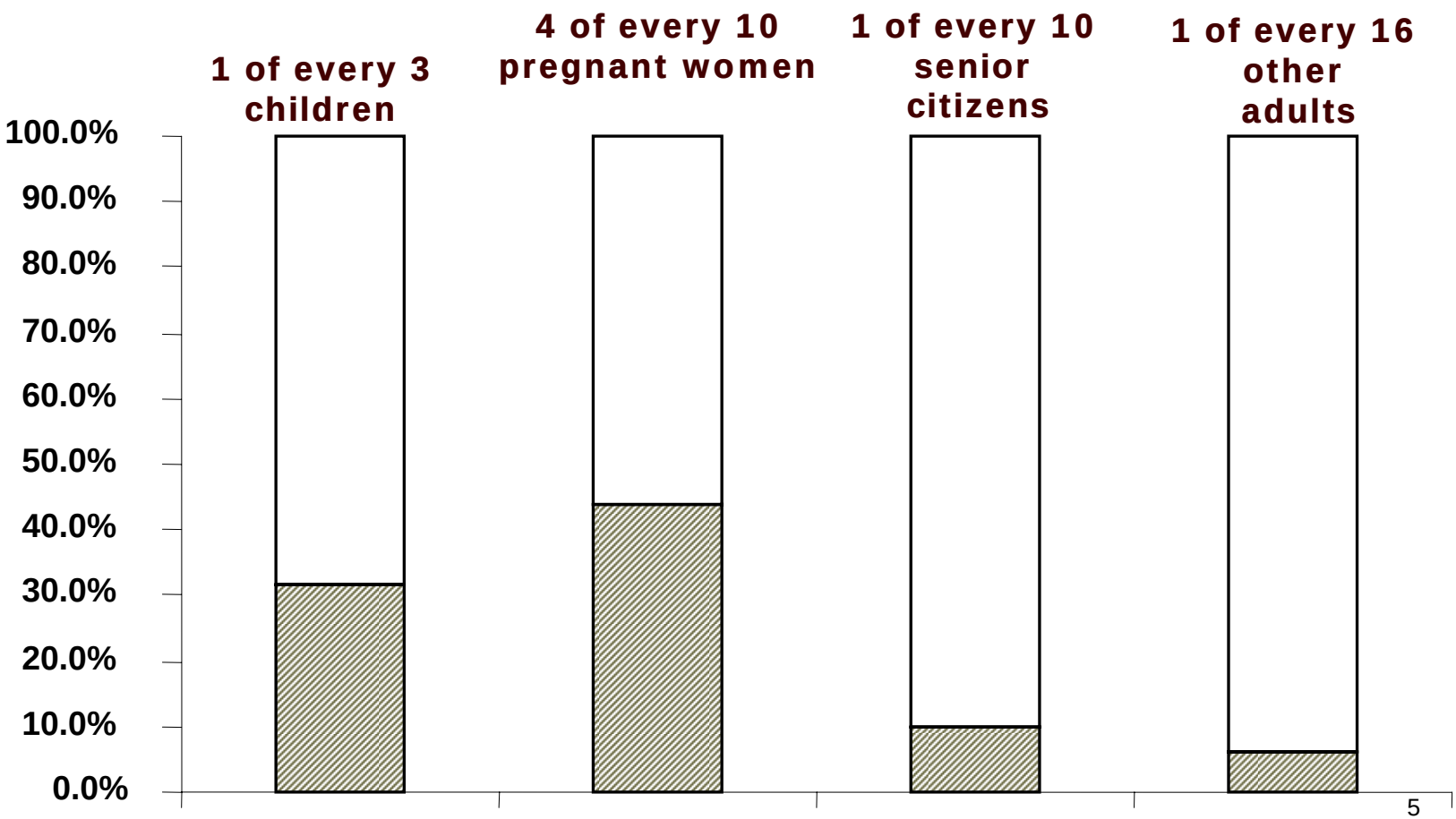
**2003-05 average monthly recipients of Basic Health (100,000) and medical assistance coverage (854,000)**




**NOTE:** Medical assistance total includes Medicaid and State Children's Health Insurance Program (SCHIP)

# The covered population

Medical assistance recipients are 15% of the state's population, including:



# Determining eligibility

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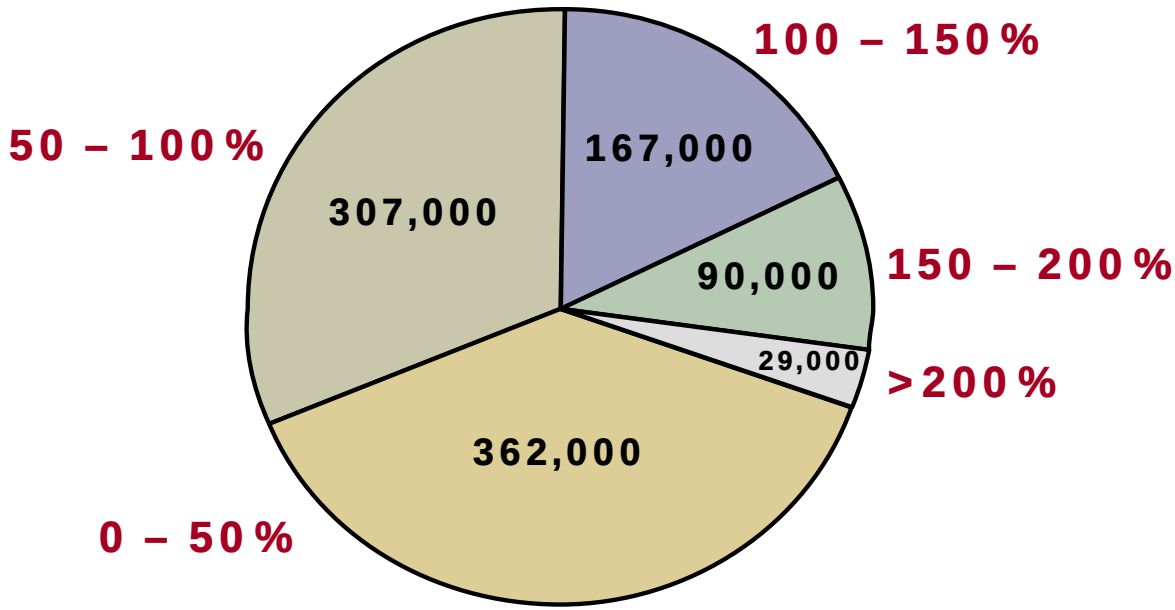
## People covered by Medicaid, SCHIP and the BHP generally have very low incomes

**Medical assistance and BHP recipient incomes as a percentage of poverty**

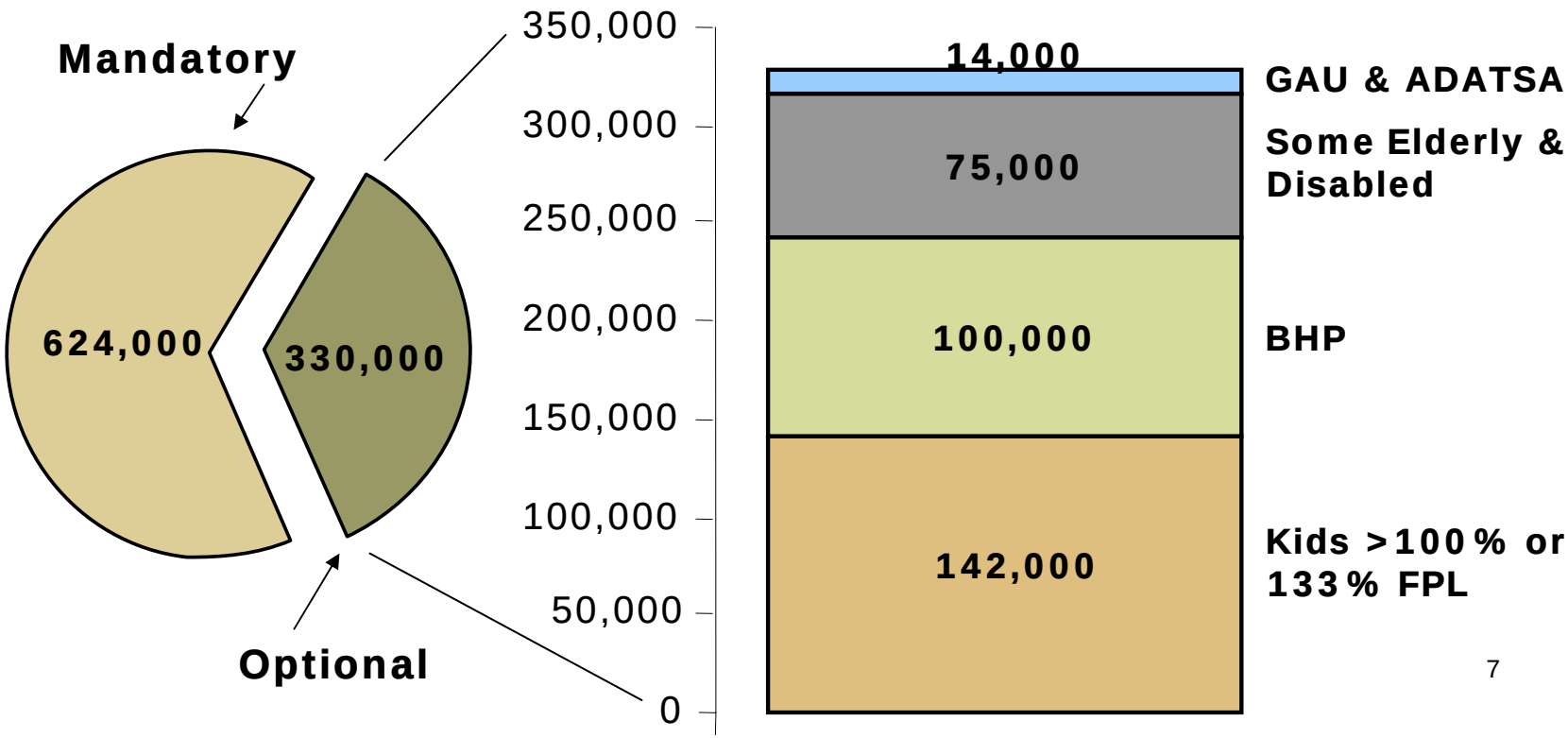



| Income for family of 4 | 100% FPL | 150% FPL | 200% FPL | 250% FPL |
|---|---|---|---|---|
| Monthly | $1,667 | $2,500 | $3,333 | $4,167 |
| Annual | $20,000 | $30,000 | $40,000 | $50,000 |

-- 2006 Federal Poverty Level guidelines, HHS

# Mandatory vs. optional

Approximately two-thirds of recipients, accounting for about three-quarters of total expenditures, must be covered under federal Medicaid rules



# Part II: Spending and caseload growth

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# Where funds come from

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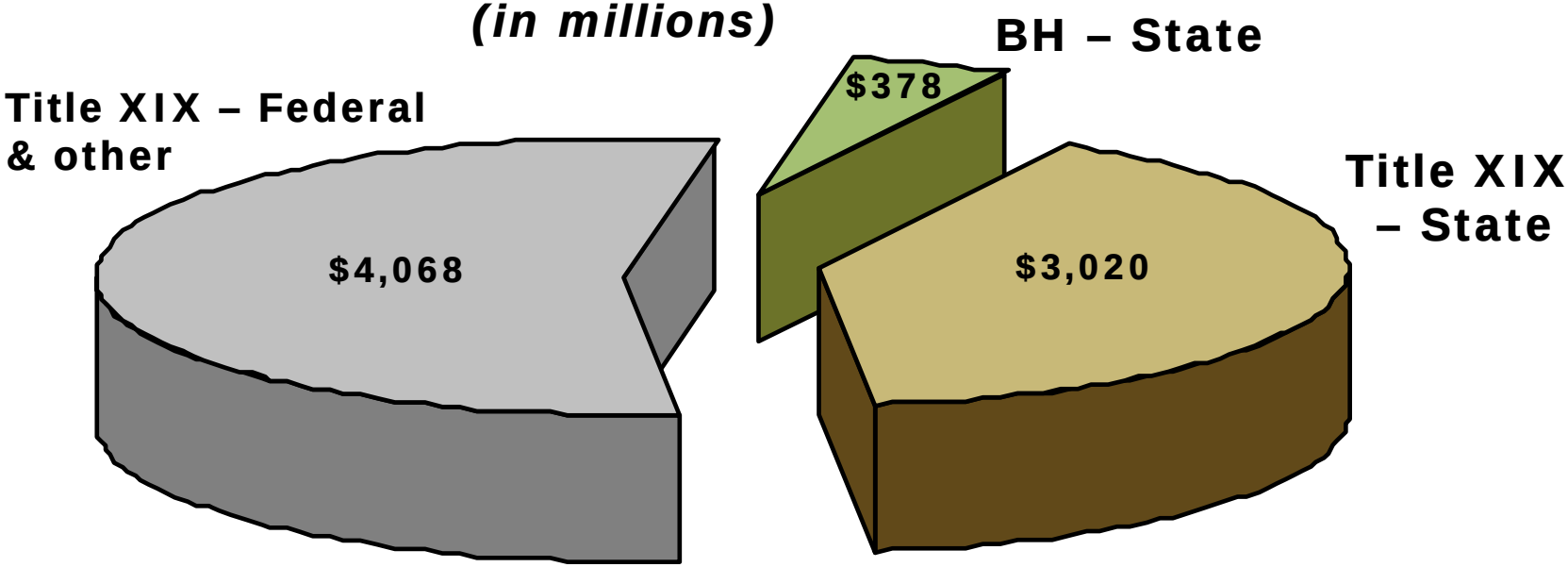
Programs will spend about $7.5 billion on medical assistance and BH this biennium, of which $3.4 billion will be from state revenues.

**Projected 2003-05 Spending**

***(in millions)***




**NOTE:** State funding provided by General Fund and Health Services Account.

# Growth of state spending

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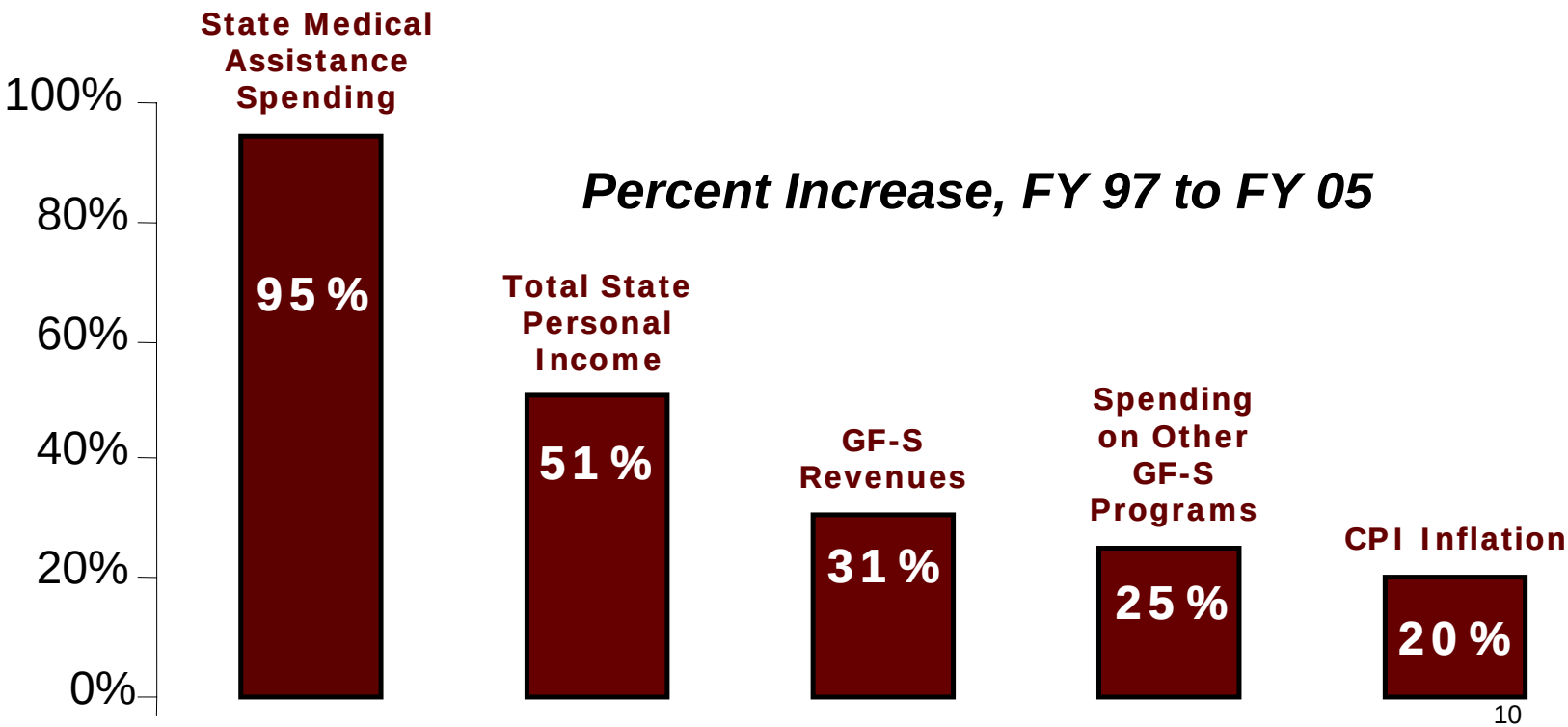
State spending on medical assistance and BH has grown much faster than state wealth, state revenues, spending on other state programs and inflation



# Factors behind rising costs

The $628 million “maintenance level” growth in current budget is due to three main factors

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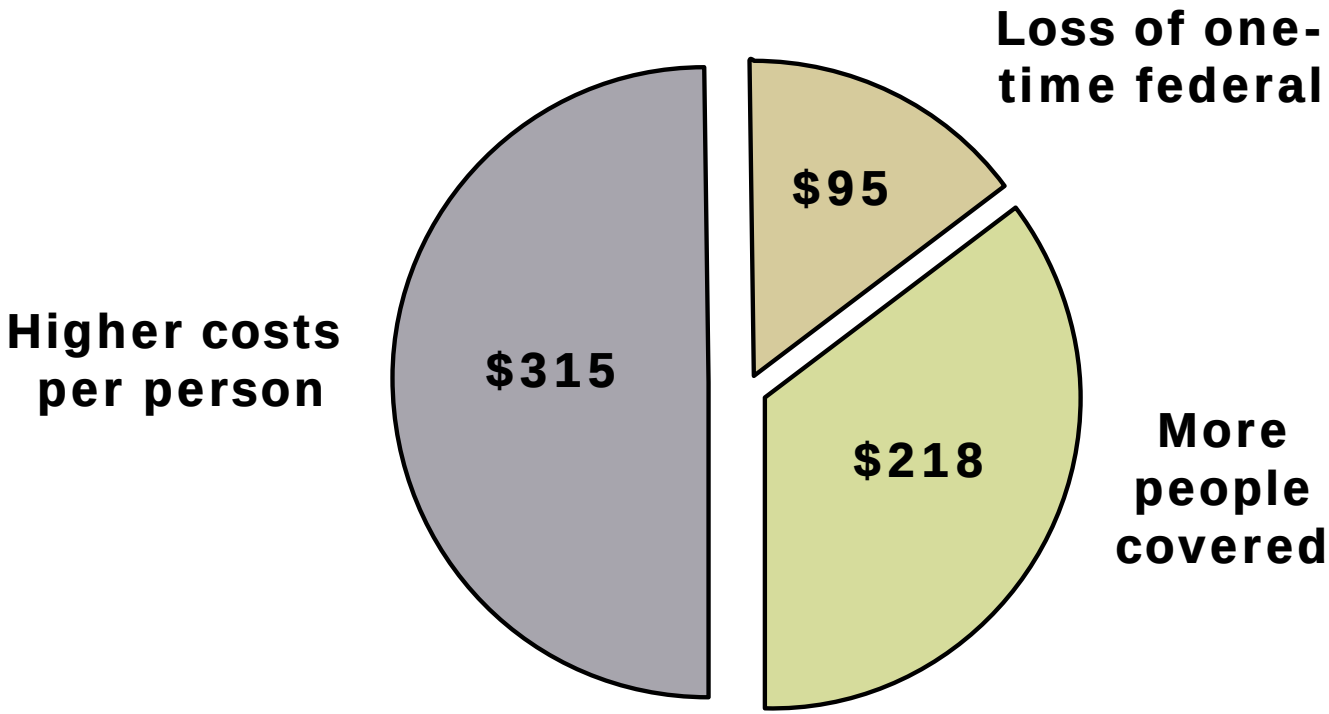
**05-07 State spending growth**
(in Millions)



# Expenditures by eligibles

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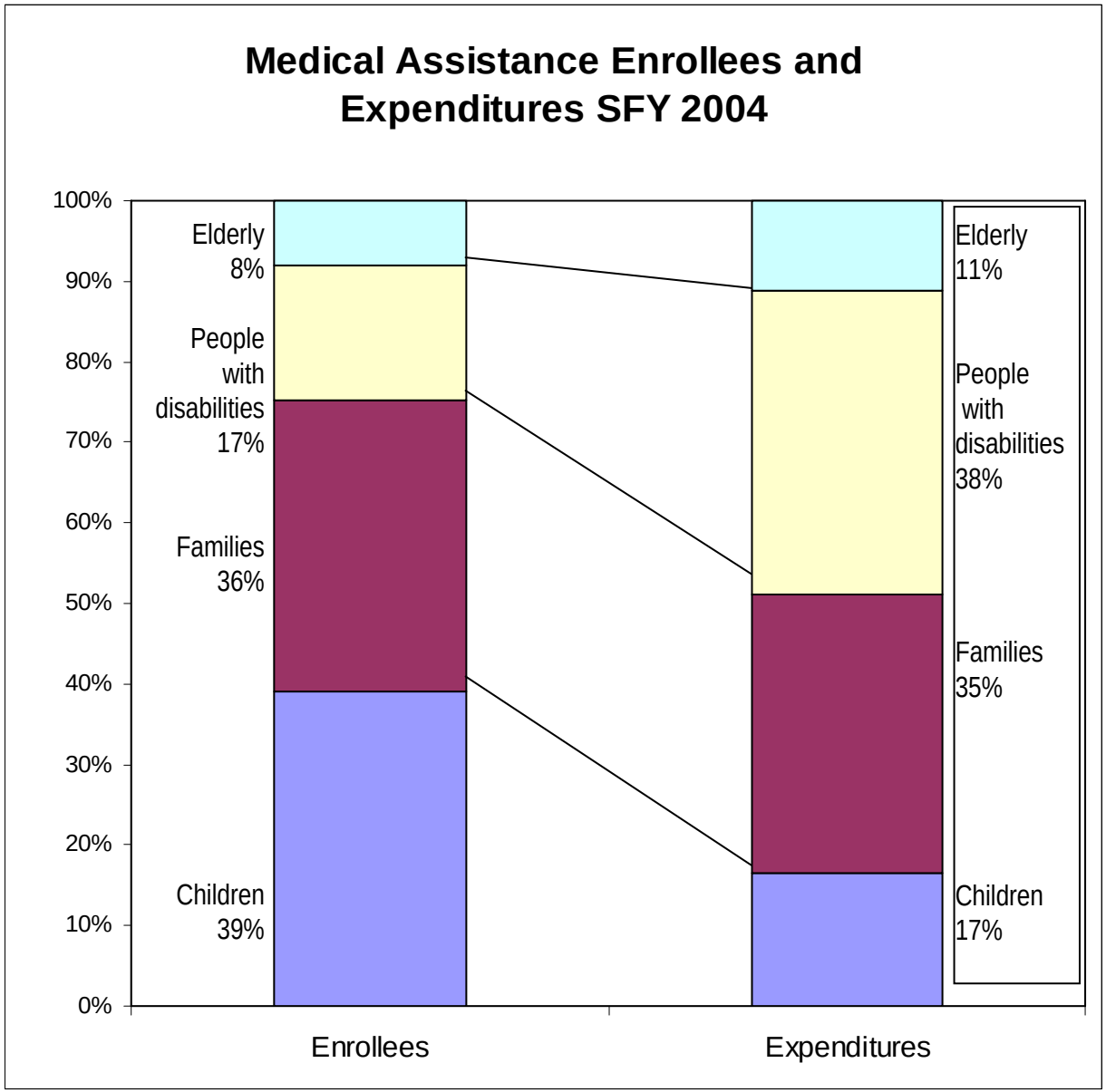

# Why caseload has grown

The state is covering more children at a rate of about 5 percent more a year. But elderly and disabled populations are also increasing at 4 percent a year.

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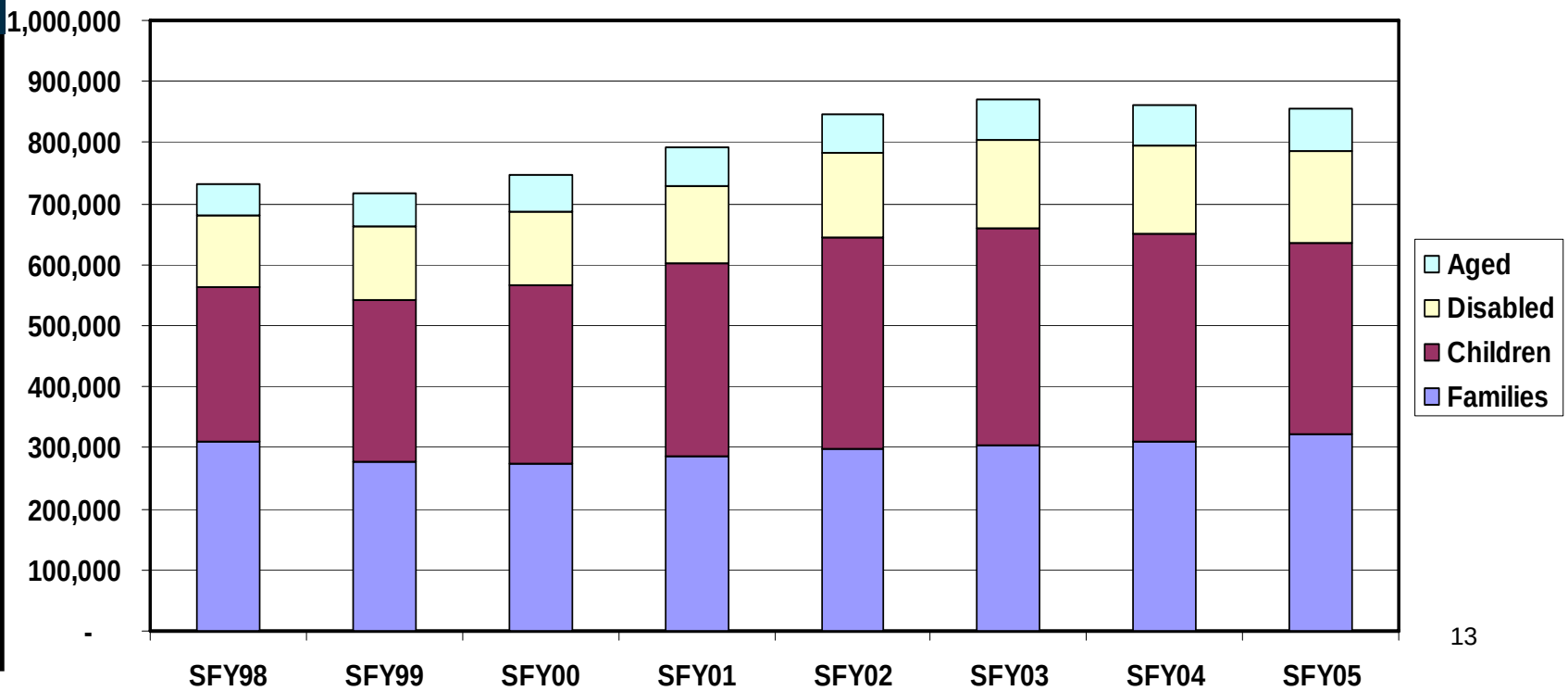
**Medical assistance enrollees over time**



# Managed care and Medicaid

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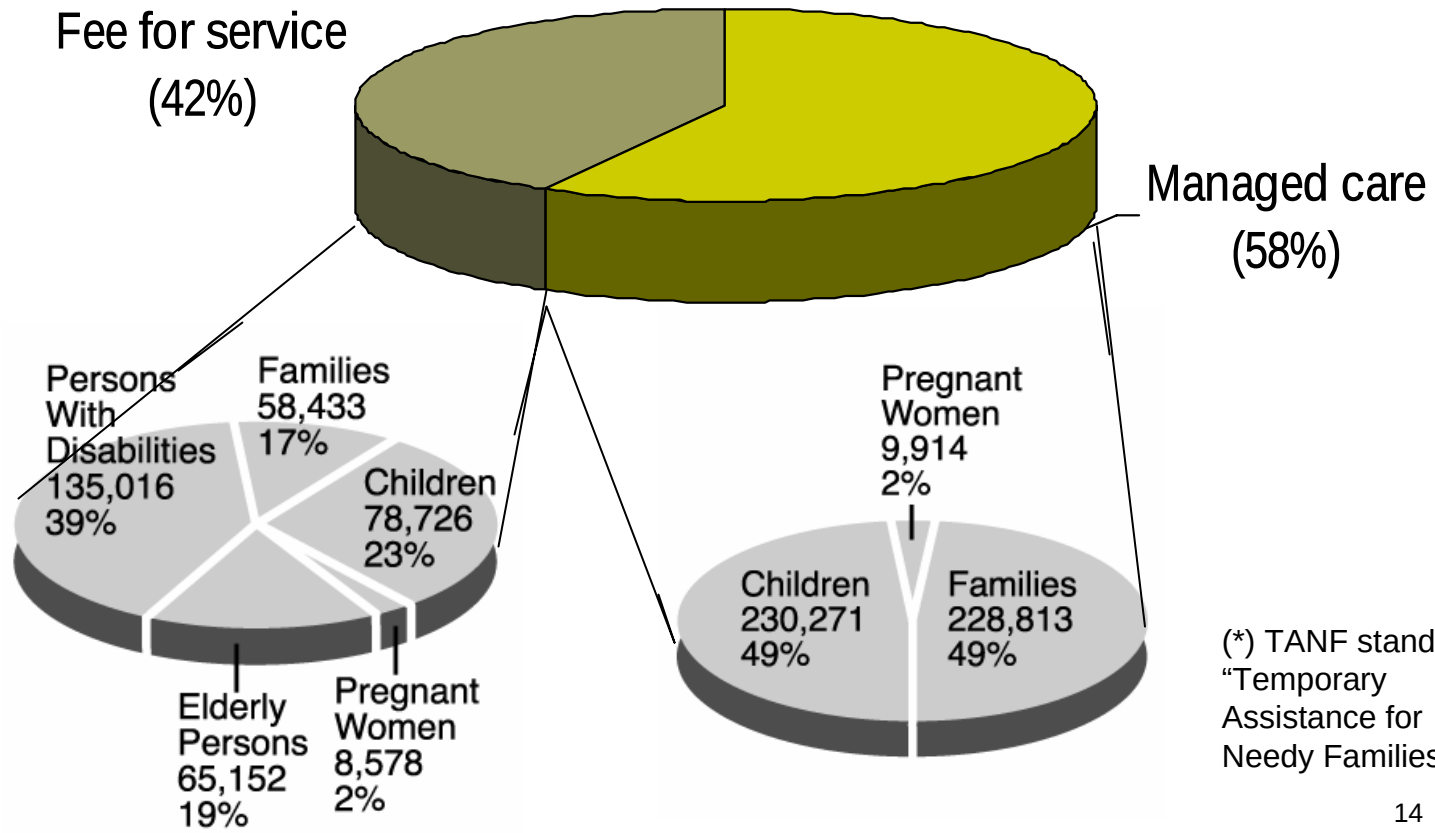
Healthy Options clients are children, TANF (*) families or pregnant women:




(*) TANF stands for "Temporary Assistance for Needy Families"

# Factors behind caseload growth

- **Private sector cuts:** Reduced dependent coverage and increased cost-sharing by employers (in response to rising health care costs)
- **Medical costs:** Cost of prescription drugs alone is a powerful incentive for enrollment
- **Elderly:** Increased lifespan as a result of ongoing advances in technology
- **Disabilities:** Baby-boomers in low-wage occupations becoming disabled as they age

# Increased utilization factors

- Technology
- Health professional labor shortages
- Large (and increasing) health sector administrative costs
- Market power of insurers, hospitals, and drug companies
- Limited ability to discourage utilization through pricing or savings incentives
- Large, growing, and expensive-to-serve elderly and disabled populations

# Part III: Realignment of HRSA in DSHS

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# DSHS organization chart

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**Secretary**
Robin Arnold-Williams

**Health and Recovery Services Administration**
Assistant Secretary
Doug Porter

- Audit and Information Systems
- Alcohol and Substance Abuse
- Business and Finance
- Customer Support
- Disability Determination Services
- Medical Management
- Mental Health
- Policy and Analysis
- Program Support

**Economic Services Administration**
Assistant Secretary
Deb Marley

- Child Care and Early Learning
- Child Support
- Community Services
- Employment Assistance Programs
- Information Technology
- Management and Operations Support
- Refugee and Immigrant Assistance

**Aging and Disability Services Administration**
Assistant Secretary
Kathy Leitch

- Developmental Disabilities
- Home and Community Services
- Management Services
- Residential Care Services

**Juvenile Rehabilitation Administration**
Assistant Secretary
Sekou Shabaka

- Community Programs
- Institution Programs
- Operations Support Services
- Treatment and Intergovernmental Programs

**Children's Administration**
Assistant Secretary
Cheryl Stephani

- Field Operations
- Information Technology
- Finance and Operations Support
- Program and Policy

**Community Outreach/ Special Initiatives**
Ed Hidano

**Deputy Secretary**
Blake Chard

- Communications
- Deaf and Hard of Hearing
- Diversity
- Government and Community Relations
- Homelessness/Housing and Services
- Indian Policy and Support Services
- Juvenile Justice
- Special Commitment Center
- Vocational Rehabilitation

**Deputy Secretary**
Liz Dunbar

- Financial Services
- Information Services
- Management Services
- Human Resources
- Government Management, Accountability and Performance

Washington State Department of Social & Health Services

Effective January 26, 2006

# Pre-HRSA: An overview

DSHS Office of the Secretary
Robin Arnold-Williams

Office of the Assistant Secretary, MAA

Asst. Secretary
Doug Porter

Deputy Asst. Secretary
Heidi Robbins Brown

**NEW on July 1, 2005**

**1. Mental Health Division**

**2. Division of Alcohol and Substance Abuse**

## Division of Customer Support

Director
Steve Wish

**DCS focuses on eligibility issues, client and provider communications, Patients Requiring Review (PRR) State Children's Health Insurance Program (SCHIP) , and Interpreter and Transportation programs.**

## Division of Audit and Information Systems

Director
Bob Covington

**DAIS operates the information systems, including MMIS and audit functions, and provides technical support for MAA**

## Division of Program Support

Director
MaryAnne Lindeblad

**DPS manages Healthy Options, Care Coordination, Family Services and Claims Processing.**

## Division of Policy and Analysis

Director
Roger Gantz

**DPA provides policy and analysis and coordinates rules and hearings**

## Division of Business and Finance

Director
Susan Lucas

**DBF maintains MAA's budget and financial operations, sets rates and supervises hospital rates and payments.**

## Division of Disability Determination Services

Director
Dr. Martin A.H. "Tony" Jones

**DDDS works with Social Security on disability determinations with branch offices in Spokane and Seattle.**

## Division of Medical Management

Director/Chief Medical Officer
Jeffery Thompson, M.D.

**DMM supervises quality improvement and monitors medical consultants; operates dental and pharmacy services in MAA**

# The Mercer realignment

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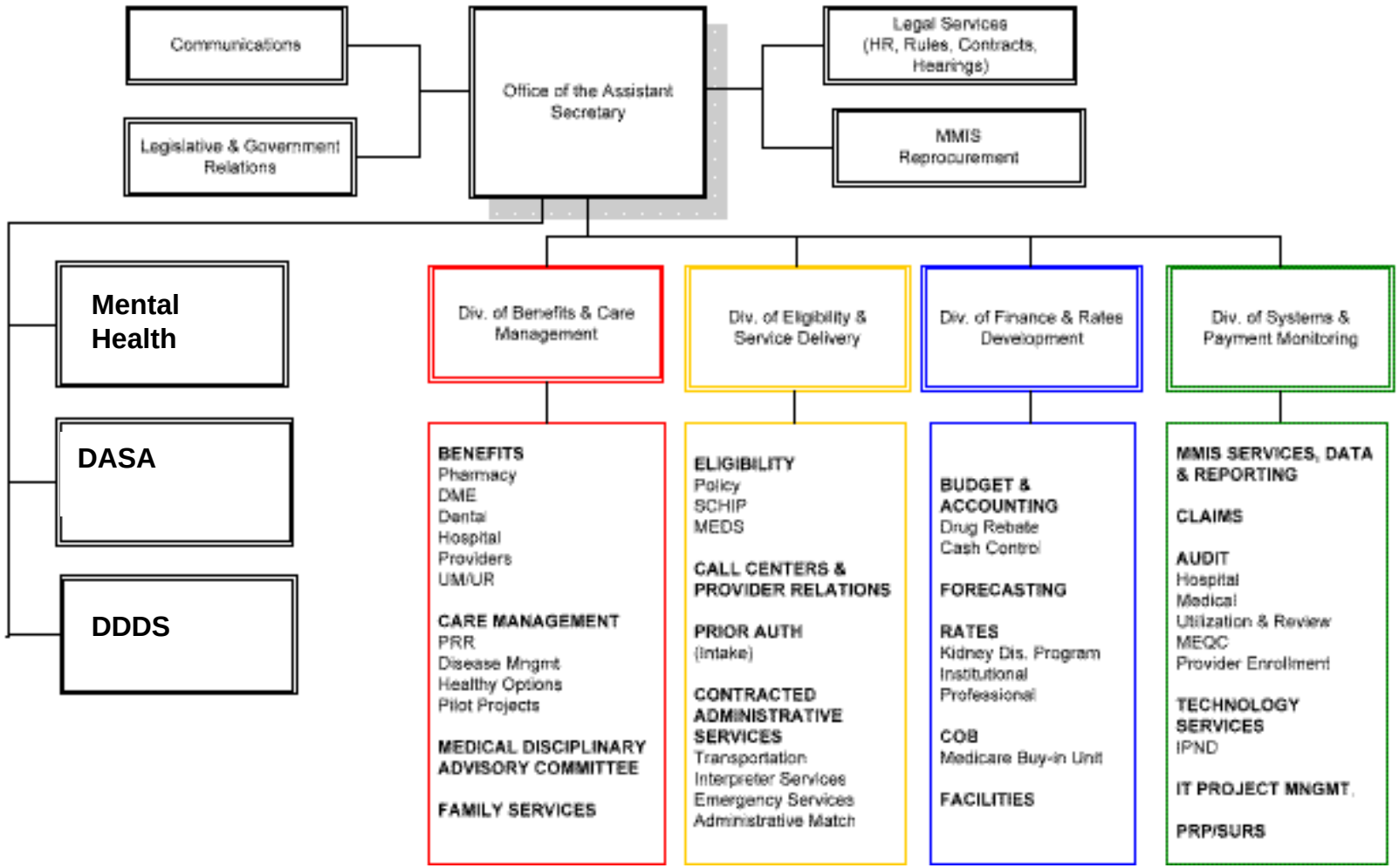
## PROPOSED HRSA ORGANIZATIONAL REALIGNMENT



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| | | |
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| Jeffery Thompson, M.D.<br>Chief Medical Officer and<br>Director, Division of Medical Management | 725-1612 | thompj@dshs.wa.gov |
| MaryAnne Lindeblad<br>Director, Division of Program Support | 725-1786 | lindem@dshs.wa.gov |
| Steve Wish<br>Director, Division of Customer Support | 725-1412 | wishss@dshs.wa.gov |
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| Doug Allen<br>Acting Director, Division of Alcohol and Substance Abuse | 725-3770 | allende@dshs.wa.gov |
| Jim Stevenson<br>Communications Director | 725-1915<br>902-7604 | stevejh2@dshs.wa.gov |
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# Part IV: Containing costs

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# Total expenditures

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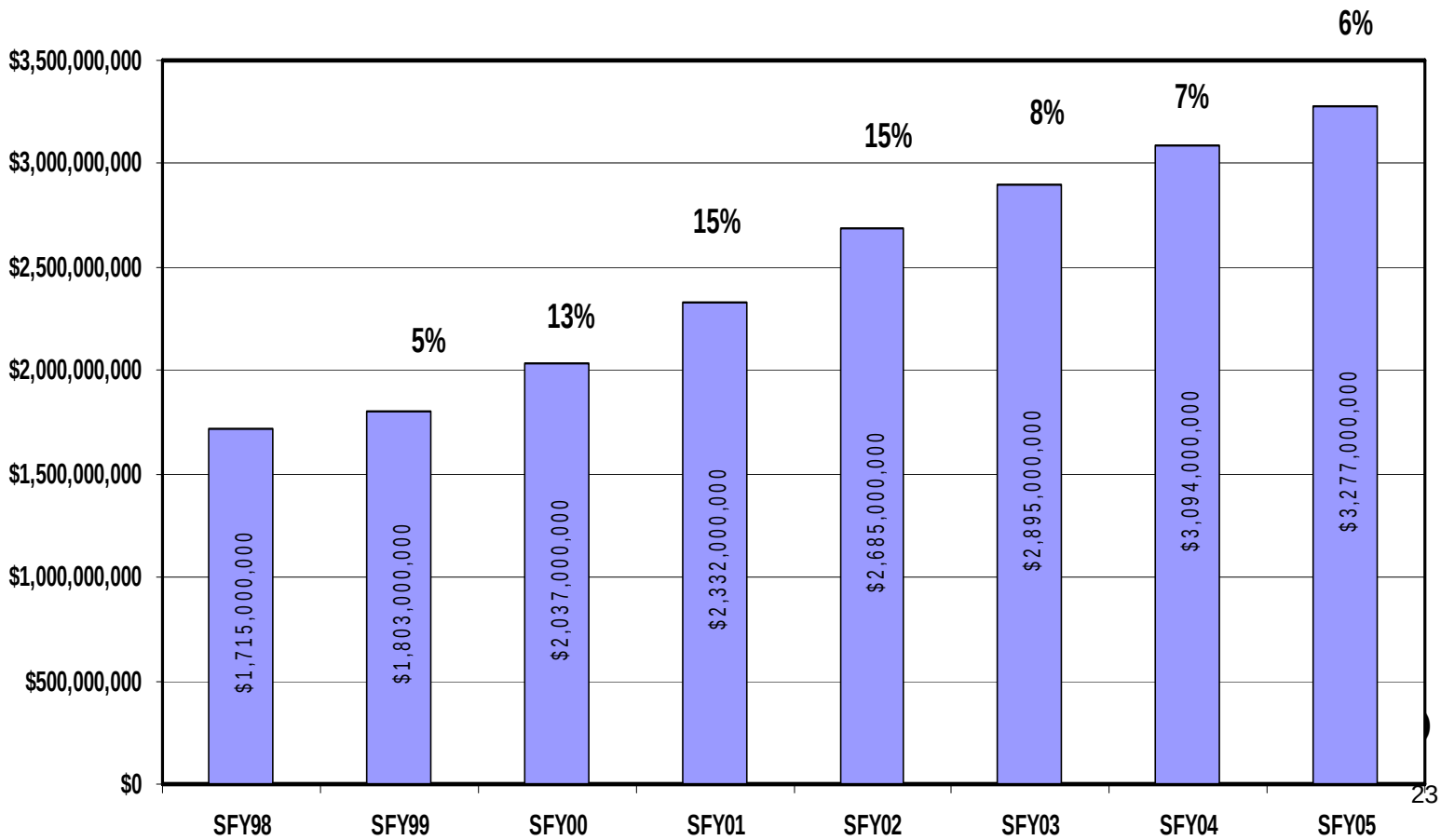
**Expenditures increased at 10 percent a year between SFY98 and SFY04. Rate has been slowing.**



# Expenditures by categories

Managed care 28%; Hospital inpatient 19%; Drugs 16%; Physicians 9%; Hospital outpatient 6%; Dental 3%

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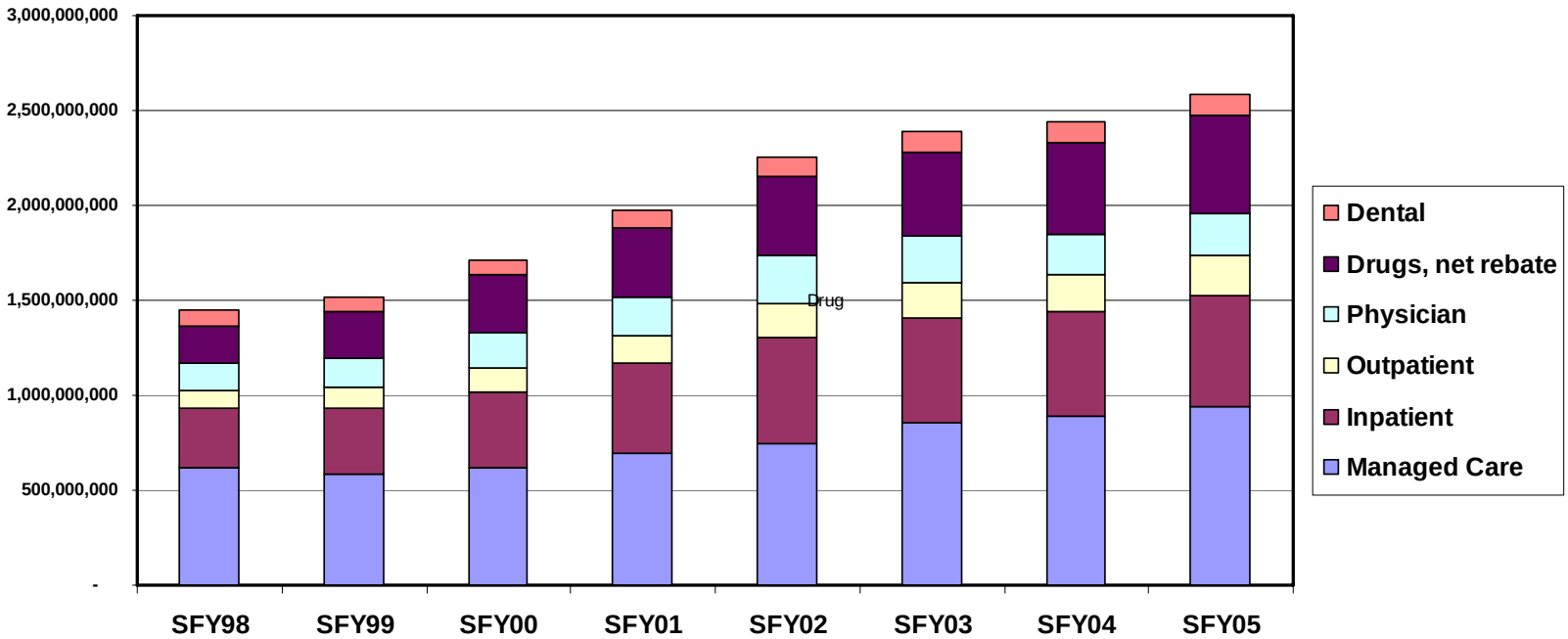
**Major medical services provided under Medicaid**




The cost of managed care and physician services held fairly steady over the past seven years, while the cost of hospital services and drugs increased significantly

# Cost containment options

- **Reduce caseload:** The number of people covered
- **Reduce benefits:** The services people are able to obtain
- **Reduce rates:** Reduce what is paid to providers, or raise levels that clients contribute to the cost of care

# Current efforts to contain costs

The 2003 and 2004 budgets directed that a number of steps be taken to reduce the growth in spending on low-income medical assistance

| Estimated 03-05 savings based on 2005 supplemental forecasts | State Funds (in Millions) |
|---|---|
| Reduce BHP enrollment to 100,000 | ($130) |
| Increase BHP enrollee cost-share | ($ 97) |
| Replace Medically Indigent Program with lidded grants | ($ 66) |
| Increase eligibility verification, require 6-month reviews | ($ 62) |
| Limit managed care rate increases to 1.5% and 5% | ($ 41) |
| No rate increases for other medical providers | N/A |
| Reduce adult dental coverage by 25% | ($ 13) |
| Establish a statewide preferred drug list | ($ 10) |
| Charge $10 premiums for children with family incomes between 150-200% of poverty | *Not implemented* |

# Despite efforts, costs still rise

State spending on DSHS Medical Assistance and the BHP is projected to grow by $628 million – more than 18% -- this biennium

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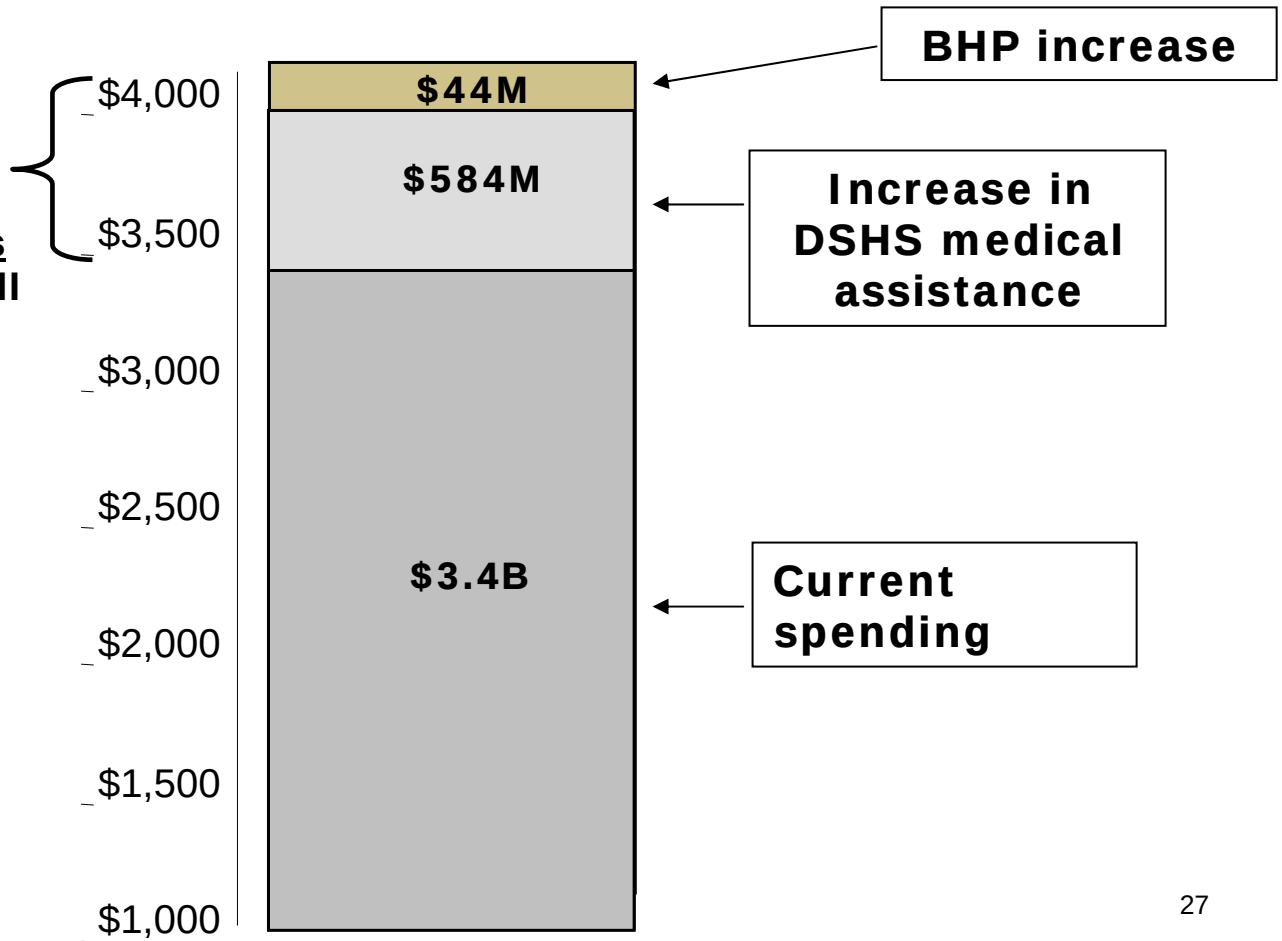
***Increase* equals <u>total</u> 03-05 GF-S budget for the 4 regional universities, <u>plus</u> financial aid at all universities.**



# Part V: Medicaid Reform

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# 4 steps to Medicaid Reform

1. **Streamlining Medicaid:** Achieve efficiencies without jeopardizing quality of care
2. **Enhancing quality and reducing costs:** Increasing cost-effectiveness and improving quality of care
3. **Slowing growth of caseload:** Reduce the trend of lower-income workforce enrolling in public health plans
4. **Slowing growth of long-term care:** Strengthen the private sector resources that can support these costs

# Streamlining Medicaid

- **Drug pricing:** Create a new Average Sales Price to reflect the actual cost of pharmaceuticals
- **Asset transfers:** Shut down inappropriate transfers
- **Cost sharing:** Realistic ways to build this participation by clients into system
- **SCHIP benefits package:** Allow flexibility in benefits package, cost-sharing and eligibility periods
- **Waiver, judicial reforms:** Provide for legislative and state flexibility
- **Managed care:** Integration of services, client-centered programs

# Slow caseload growth

- **Individual health-care tax credits:** A benefit available to all low-income individuals as a premium subsidy paid directly to the health-care provider
- **Employer tax credits:** Supporting benefits for low-paid workers and their families
- **State purchasing pools:** Organized on a large-scale basis with benefits available to both small businesses and individuals

# Slow growth of long-term care

- **Reverse mortgages:** A painless way for many individuals to pay for long-term care even if other assets have been exhausted
- **Tax credits for long-term care insurance:** Encourage purchase of coverage at younger ages
- **Long-term care partnership:** Repeal federal ban on backstop coverage to reward those who purchase private long-term care coverage
- **Integrate "dual-eligibles" into Medicare:** Over 10-15 years, move out-of-pocket costs and long-term care out of Medicaid

# Current initiatives

- **Information upgrades**
  - ProviderOne: new Medicaid Management Information System (MMIS)
  - Streamline provider billing
- **Fiscal integrity**
  - Strengthen Medicaid eligibility determination
  - Increase Payment Review Program (PRP) and audits
  - Continue efforts to expand Coordination of Benefits
  - Rates: Outpatient Prospective Payment System (OPPS)
  - DDDS Cooperative Disability Investigations (CDI)
- **Improved quality of care**
  - Implement Medicaid integration pilot/Snohomish County
  - Implement managed care GA-U pilot
  - Continue evaluation of Disease Management program
- **Medical management**
  - Washington Preferred Drug (SB6088) Program
  - Evidence-based medicine guidelines
  - Expand Patients Requiring Review (PRR) program
  - Prior authorization strategies for medical nutrition

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# QUESTIONS?

**Doug Porter**

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